

He gives a minute description of these findings in the *Archiv für Psychiatrie*.

(Vol. 28, No. 185, March 15, 1905.)

1. Delusion and Personality. LOMER.
2. On the Nature and Specificity of the Toxic Substances Contained in the Blood Serum of Epileptics. CENI.

1. *Delusion and Personality*.—A Speculative Psychological Essay.

2. *The Toxin in the Blood of Epileptics*.—From a new series of experiments Ceni draws the following conclusions: "The serum of epileptics injected into other epileptics in the dose of 10 c.c. produces no acute phenomena. In severe cases, especially in the "status," the blood serum is decidedly hypertoxic, producing headache, confusion, fever and an aggravation of the epileptic symptoms. The grade of toxicity is not proportionate to the severity of the case. A patient's own hypertoxic serum injected into himself between attacks poisons him, but in an attack has no effect. The hypertoxicity anticipates by some days an attack. In healthy men and animals the epileptic serum is comparatively inert.

(Vol. 28, No. 186, April 1, 1905.)

1. On the Conception and Significance of Aphasic Disturbances in Epileptics. HEILBRONNER.

1. *Aphasic Disturbances in Epileptics*.—This is the report of a case in which speech disturbance was occasional, appearing the first time in connection with a psychosis; later independently of other mental disturbance, but always after the epileptic attacks. It is of the amnesic variety, which may point to definite sensory areas as the source of epilepsy in these cases. PICKETT (Philadelphia).

Revista di Patologia Nervosa e Mentale.

(February, 1905.)

1. The Westphal-Strümpell Disease. REBIZZI.
2. Laminectomy of the Third and Fourth Lumbar Vertebrae for a Lesion of the Cauda Equina. ALESSANDRI.

1. *The Westphal-Strümpell Disease*.—Continued.

2. *Laminectomy for Lesion of Cauda Equina*.—The patient, male, age 36, with marked tubercular history. When first came under observation was suffering with anesthesia, with which was associated a great deal of pain. A diagnosis of disease of the cauda equina was made and laminectomy done on the 17th of April. Adhesions and effusion were found. The patient was discharged from the hospital the first of August much improved. The pain had disappeared, though much anesthesia and impaired motion remained.

(March, 1905.)

1. The Westphal-Strümpell Disease, Westphal Type, Pseudo-sclerosis and Strümpell Type, Diffuse Sclerosis. REBIZZI.

1. The Westphal-Strümpell Disease, Westphal Type, Pseudo-sclerosis and Strümpell Type, Diffuse Sclerosis. REBIZZI.

1. *The Westphal-Strümpell Disease* (concluded).—The author believes that pseudo-sclerosis and diffuse sclerosis are one and the same disease and proposes the name Westphal-Strümpell disease for it, referring to pseudo-sclerosis as the Westphal type and diffuse sclerosis as the Strümpell type. The clinical analogies of the two types are well shown in the following table:

DIFFUSE SCLEROSIS.	PSEUDO-SCLEROSIS.
Very rarely hereditary antecedents.	Neuroses and psychoses in the antecedents.
In the personal antecedents is noted the presence of trauma, intoxications, acute infectious diseases, syphilis.	In the personal antecedents intoxications, acute infectious diseases, syphilis.

Sexual indifference.

Beginning in infants as well as in adults.

Mean duration of the disease from 1 to 10 years.

Only light remissions observed; progressive course.

Grave state of prognostic dementia with motor agitation, accesses of furor, spasmodic laughing and crying, hallucinations, occasional euphoria, delirious ideas.

Vomiting, vertigo, syncope, epileptiform and apoplectiform attacks.

Marked disturbance of speech, ending in incomprehensible language, very rarely scanning of the words, often aphasia.

Expressions slow and rigid.

Frequently paralysis in the field of the facial, always unilateral, localization variable in the different branches, often transitory. Paralysis of the hypoglossal often transitory and of the motor branch of the trigeminus.

Disturbance of deglutition very frequent.

Nystagmus, paralysis of the ocular muscles, sometimes transitory, pupillary asymmetry, tardy reaction, rigidity.

Ophthalmoscopic examination always shows lesion of the papilla.

Diminution of hearing.

Slowness of all the muscular movements.

Paralysis and spastic paresis with contracture; sometimes transitory. Often hemiplegia of one side and hemiparesis of the other.

Increased tendon reflexes, rarely absence; ankle clonus, Babinski sign.

General increase of the muscular tone. Rigidity.

Tremor and ataxia in voluntary acts a little less frequent than in pseudo-sclerosis, but more frequently than in it; tremor during repose; frequently clonic contractions. Diffusion of the tremor variable; sometimes in the head and tongue.

General weakness. Walking uncertain or impossible, due to paralysis, spasms, tremors.

Sexual indifference.

Beginning in infants as well as in adults.

Mean duration of the disease from 1 to 10 years.

Remissions in the course of the disease, progressive course.

In the initial period slight mental deterioration, apathy, followed by accesses of furor, spasmodic laughing and crying, resulting in dementia, occasionally somewhat accentuated.

Vertigo, syncope, epileptiform and apoplectiform attacks, rarely vomiting.

Disturbance of speech, scanning and slow speech, disturbances similar to those of bulbar affections, the language finally becoming incomprehensible.

Expressions slow and rigid.

Trifling paralysis of the hypoglossal and of the motor branch of the trigeminus, rarely a disturbance of deglutition.

Nystagmus rare. Once a trifling pupillary asymmetry.

Ophthalmoscopic examination negative. Once amblyopia.

No recorded disturbances of the other organs of special sense.

Slowness of all the muscular movements.

Paralysis and spastic paresis with contracture of variable location, transitory then lasting.

Increased tendon reflexes, ankle clonus.

General increase of the muscular tone. Rigidity.

Tremor usually intention and ataxia of the upper extremities, sometimes with diffusion also to the inferior. Sometimes also tremor in repose. No clonic contractions. Tremor sometimes in the head or the face and in the tongue.

General weakness. Walking uncertain or parietic-spastic.

Often diminution of cutaneous reflexes.	No alterations of the cutaneous reflexes described.
Vasomotor and trophic disturbances. Sometimes muscular atrophy.	Neither vasomotor or trophic disturbances frequent.
Frequent eruptions of acne and comedones.	Frequent eruptions of acne and comedones.
Pain, paresthesia. Objective disturbances of sensibility much more frequent than in pseudo-sclerosis, namely, hypoaesthesia; hypalgesia often more marked on one side.	Pain, paresthesia. Generalized hypoaesthesia.
Disturbances of the rectum and bladder.	Disturbances of the rectum and bladder not frequent.
Bed sores.	Bed sores infrequent.
Fatal termination always.	Fatal termination always.

WHITE.

Journal de Psychologie, Normale et Pathologique.

(Second year, No. 2. March-April, 1905.)

1. The Physiopathological Problem of Responsibility. J. GRASSET.
2. Persecutional Delirium Among Three Associates, with Self-imposed Sequestration. D'ALLONNES and JUQUILIER.
3. Clinical Report of a Case of Retro-antegrade Amnesia following hanging, with Bibliography. SERIEUX and MIGNOT.
4. Note upon Psychasthenic "Distress." P. HARTENBERG.

1. *The Physiopathological Problem of Responsibility.*—As is well known, there is much confusion among medical witnesses, when testifying in court, in regard to the degree of responsibility possessed by the prisoner. Grasset attempts most ingeniously to explain the *raison-d'être* of this confusion and to suggest a way whereby it may be avoided. In his thesis he adopts the teachings of himself, Janet and others in regard to the existence of a superior (conscious) and an inferior (subconscious) mind.

In the first place, he declares that the medical experts should always be careful to separate sharply the philosophical question of responsibility from the medical or psychophysiological question. He should, in his testimony, always limit himself strictly to the latter. Can he do so? Yes, for it will be conceded by court and expert alike that abnormal mentalization must be dependent upon abnormal anatomico-physiological conditions, and a discussion of these conditions is the medical experts' particular province. The degree of *legal* responsibility that is to be associated with these abnormal states of mentalization, borne witness to by the medical experts, is a question solely for the court to decide. Medical responsibility is, or may be, something quite different from legal responsibility, hence the confusion surrounding this question when it is under discussion in a criminal court.

Grasset then further discusses medical responsibility and shows that there are three sets of mental diseases, as it were, in each of which the responsibility is quite different. In the first place, he distinguishes clearly those affections of the superior mind (mental diseases) from those of the inferior mind (psychic diseases). Herein he shows that the terms psychic and mental are not synonymous. Psychic is synonymous with cortical and is therefore far more general in its significance than is mental, which, in signification, is rather more limited and refers functionally only to the prefrontal lobe.

Irresponsibility accompanies the diseases of the superior mind, the true mental diseases; responsibility or partial responsibility accompanies always the diseases of the inferior mind, the mere psychoses. Mania is